

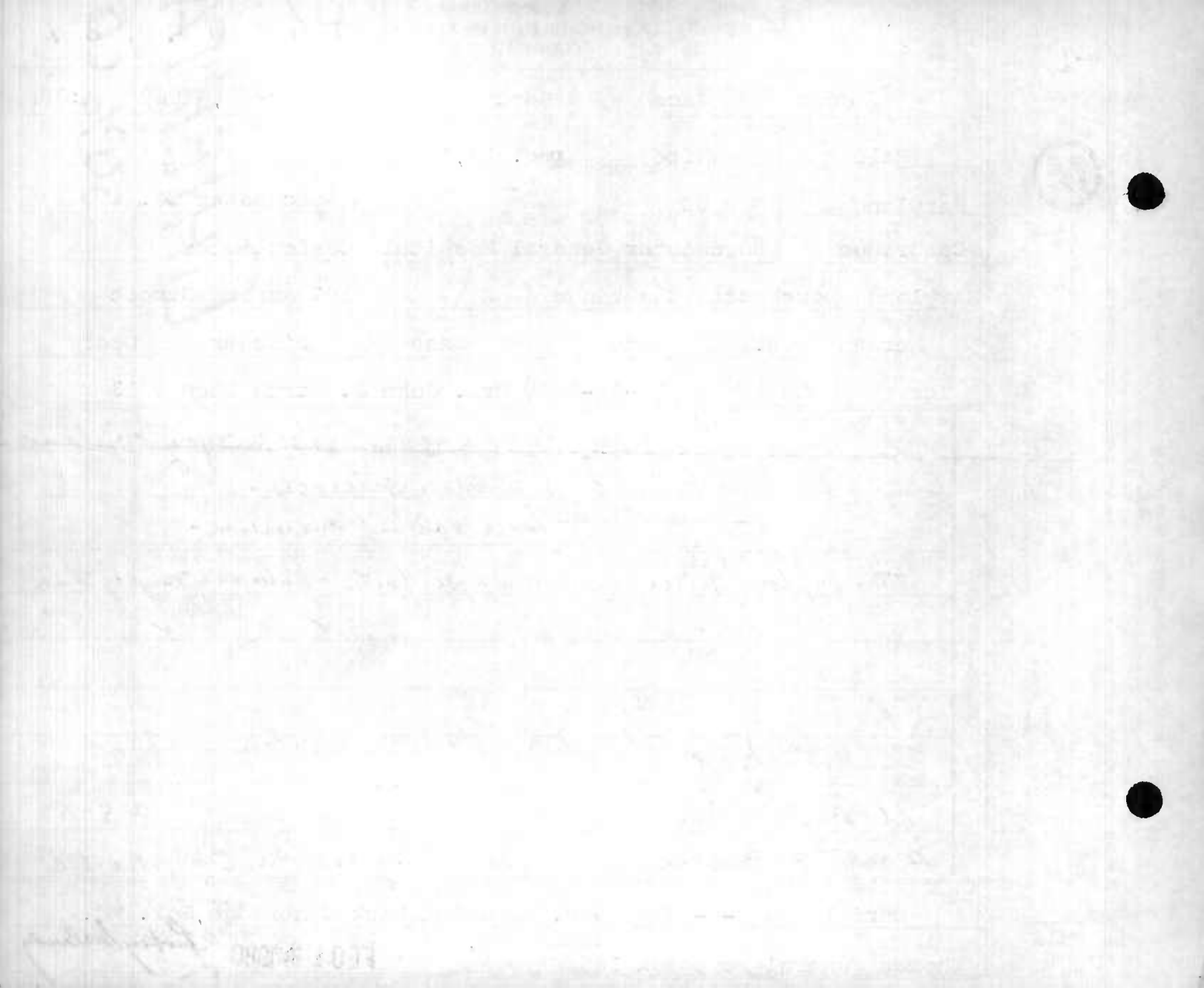
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8 0 0 4 4 8 7									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
John		Jacob		Barth				February 5, 1980		4:30P ^M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR MONTHS DAYS		7 IF UNDER 24 HRS. HOURS MIN.	
Male		White		Aug. 18, 1894		85 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		US				Dorchester Co. MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Dorchester General Hospital						Confectioner			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Dorchester		Cambridge						107 Aurora Street	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Herman W. Barth		Anna Fischer Deer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
Yes		WW I		214-32-1029 Mrs. John J. Barth Item # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Heart Disease with Cardiomegaly</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>orn 10 yrs</u>	
4140 } CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Due to, or as a consequence of Generalized coronary sclerosis -</u>											
} <u>Due to, or as a consequence of Large abdominal aneurysm -</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): <u>Two pyloric ulcers with recent perforation - Pyloric empty by surgery</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>March 10, 1980</u> to <u>Feb 5, 1980</u> , that (I) (we) last saw the deceased alive on <u>Feb 5, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
<u>Albert E Bunker</u>		28-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Albert E Bunker		200 Maryland Ave, Cambridge Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		2-8-80		Bor. Memorial Park		Cambridge, Dor. Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Thomas Funeral Home Box 348 Maryland		Cambridge,		FEB 13 1980		<u>Robert H. Bunker</u>					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) BLANCHE M. CHESTER			2a. DATE OF DEATH MONTH DAY YEAR FEBRUARY 20, 1980		2b. HOUR M
3 SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR AUG. 28, 1908	6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.		
10. CITY OR TOWN OF DEATH CAMBRIDGE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 506 CLINTON STREET		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER	12b. KIND OF BUSINESS OR INDUSTRY RET.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY DORCHESTER	13c. CITY OR TOWN CAMBRIDGE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE OPIER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MANNIE WATERS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-10-8004	17. INFORMANT ADDRESS WILLIAM GILES CAMBRIDGE, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma Metastatic to liver with unknown primary 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from 08-31-79 , 19____, to 02-20- , 19 80 , that (I) (we) lost saw the deceased alive on January 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. Edwin Fasset</i>				22c. DATE SIGNED 02-21-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. EDWIN FASSETT, M.D.				22e. ADDRESS 306 FAIRMOUNT AVE. CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/23/80	23c. NAME OF CEMETERY OR CREMATORY BETHEL		23d. LOCATION CITY OR TOWN COUNTY STATE CAMBRIDGE DOR. MD.
24. FUNERAL DIRECTOR <i>St. Clair F. Home</i>			25a. DATE REC'D. BY REGISTRAR FEB 27 1980		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1. FOR STATE REGISTRAR					8 0 0 4 4 8 9					
CERTIFICATE OF DEATH					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) BESSIE V. Cockey					2a. DATE OF DEATH MONTH 2 DAY 26 YEAR 80					2b. HOUR 2:30 AM
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH 08 DAY 01 YEAR 95		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? MARYLAND		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD.				
10. CITY OR TOWN OF DEATH Cambridge Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House Nursing				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER		12b. KIND OF BUSINESS OR INDUSTRY BOARDING		
13a. STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN CLAIBORNE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS MAPLE HALL		
14. FATHER'S NAME FIRST Thomas MIDDLE W. LAST TROTT					15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE JANE LAST Mc Garry					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-16-7697A		17. INFORMANT ADDRESS ALICE W. COOK CLAIBORNE, MARYLAND						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Cardio-Pulmonary Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Possible Myocardial Infarction (c) ASCVD: A. fibrillation										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Organic Brain Syndrome										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. Tanman					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman					22e. ADDRESS 17 Franklin St. Cambridge, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE FEB. 29. 1980		23c. NAME OF CEMETERY OR CREMATORY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE CLAIBORNE TALBOT MD				
24. FUNERAL DIRECTOR NAME Heimer E. Leonard ADDRESS St. Michaels, Md. 21663					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Robert McCready			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 0 0 4 4 9 0

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ida R. Cody			2a. DATE OF DEATH MONTH DAY YEAR 2 10 80			2b. HOUR 6 P M				
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 8 5 82		6 AGE (IN YEARS LAST BIRTHDAY) 98 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Taipei		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD				
10 CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cannery		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. CITY OR TOWN CAROLINE Greenboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P.O. Box 13, Maple Ave	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES HARRIS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 927-16-7623			17. INFORMANT ADDRESS ROLAND HARRIS, RFD1 BOX 12 CORDOVA MD.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4/140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a), stating the } underlying cause last. } (b) Coronary H. Disease (c) Generalized Atherosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CH Failure										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE E. Tanman			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-10-80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman			22e. ADDRESS 17 Franklin St. Cambridge, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/13/80		23c. NAME OF CEMETERY OR CREMATORY DENTON CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE DENTON CAROLINE MD			
24. FUNERAL DIRECTOR NAME ADDRESS MOORE FUNERAL HOME DENTON, MD.						25a. DATE REC'D. BY REGISTRAR FEB 14 1980		25b. REGISTRAR'S SIGNATURE Hester McCreedy		

MEDICAL CERTIFICATION

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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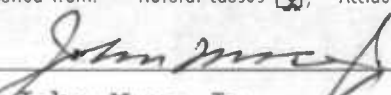
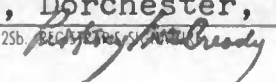


CHURCH

FOR STATE HEALTH DEPT.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 4 4 9 1

1. DECEASED NAME (Type or Print) CATHERINE TILMAN DEAN			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month 2 Day 4 Year 1980			2b. HOUR 8:30			
3. SEX female	4. RACE cau.	5. DATE OF BIRTH 9/26/1923	6. AGE (In years last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS 0	DAYS 0	IF UNDER 24 HRS HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month 2 Day 4 Year 1980	2d. HOUR 8:30
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester			
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dorchester Gen. Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerk			12b. KIND OF BUSINESS OR INDUSTRY credit union
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 703 Maryland Ave.	
14. FATHER'S NAME First Henry Middle Tilman Last Dean			15. MOTHER'S MAIDEN NAME First Ethel Middle Wagner Last Dean						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 215-12-6289		17. INFORMANT husband			ADDRESS G. Winfield Dean, same as 13e		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410- Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Min.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____	State _____
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE 			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 2/4/80			
EXAMINER'S NAME (Type) John Mace Jr.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 2/6/1980		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION (City or Town) (County) (State) Beulah, Dorchester, Md.			
24. FUNERAL DIRECTOR Curran Funeral Home, 308 High St.				25a. RECEIVED BY REGISTERED FEB 11 1980		25b. SIGNATURE OF REGISTERED 			

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event within 72 hours after death.

2025 COLLOM 418

CHIEF V. L. BOND

Clinton County Home, 302 High St.
Syracuse, N.Y.

Serial 5717-40 Mr. Votaw, Gen. Sec.,
Syracuse, N.Y.

John Hays, Jr.

[Handwritten signature]



Officially designated

7-12-43 H. H. Hays, Jr. Sec. of the

Henry

William

Richard

Robert

Cambridge

Westchester Co. N.Y.

Clark

Marshall

Westchester

Serial 5717-40 7/12/43

CHIEF V. L. BOND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 20M
(VRS 15, 4) 7/78

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 0 4 4 9 2
CERTIFICATE OF DEATH

FOR
1. STATE
REGISTRAR

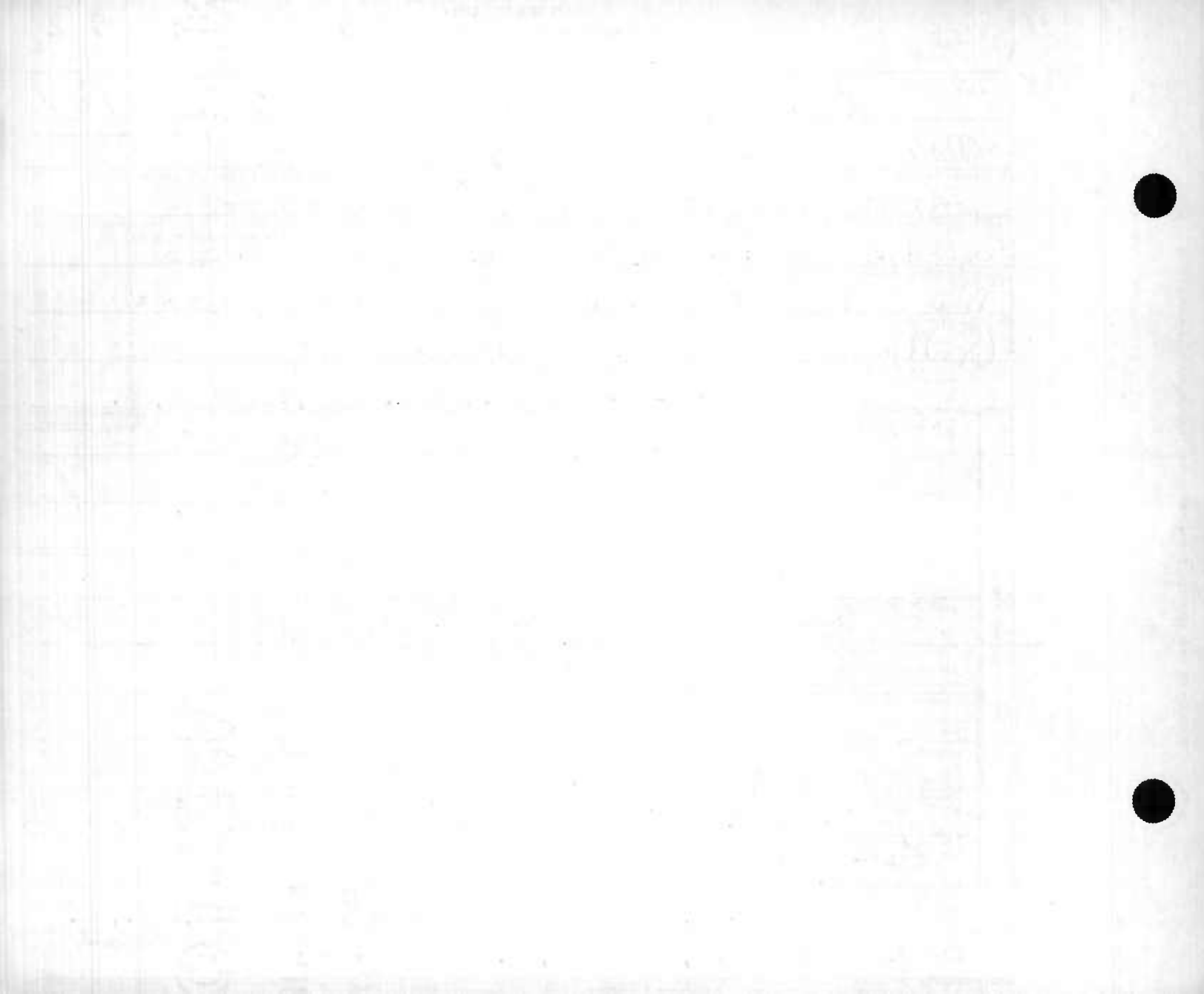
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LLOYD J. DIXON			2a. DATE OF DEATH MONTH DAY YEAR 2 23 80			2b. HOUR 1:22 P.M.		
3 SEX MALE			4 RACE CAU.			5. DATE OF BIRTH MONTH DAY YEAR 8 12 06		
6 AGE (IN YEARS LAST BIRTHDAY) 23 YRS			7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U. States		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10 CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Bus Guard		
12b. KIND OF BUSINESS OR INDUSTRY			13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13b. STREET ADDRESS 905 Springfield Ave.			14 FATHER'S NAME FIRST MIDDLE LAST William Dixon					
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Hall			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					
16b. SOCIAL SECURITY NO. 217-10-8756			17 INFORMANT ADDRESS Mrs. Dora R. Dixon, Cambridge, Md.					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PROLIFERATING BLADDER CARCINOMA</u> 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROLIFERATING BLADDER CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>PROLIFERATING BLADDER CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos. Early.	
--	--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>None</u>			
19a. DATE OF OPERATION 1978		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PROLIFERATING BLADDER CARCINOMA	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) lost view the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Thomas J. Devine</u>		22c. ADDRESS <u>Thomas J. Devine</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Thomas J. Devine</u>		22e. ADDRESS <u>Thomas J. Devine</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 26, 1980		23c. NAME OF CEMETERY OR CREMATORY Dixon Fam Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lakesville, Dor. Md.	
24 FUNERAL DIRECTOR Thomas Funeral Home, Cambridge, Md.				25a. DATE REC'D. BY REGISTRAR FEB 29 1980		25b. REGISTRAR'S SIGNATURE <u>Patricia Kelly</u>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (S))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		FIRST Gertrude		MIDDLE Fisher		LAST Fisher		7a. DATE KNOWN OF DEATH ESTIMATED		MONTH 2		DAY 25		YEAR 1980		7b. HOUR 2AM					
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 11/11/1917		6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD		MONTH 2		DAY 25		YEAR 1980		7d. HOUR 2A					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County											
10. CITY OR TOWN OF DEATH Cambridge				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.				13b. COUNTY Dor.				13c. CITY OR TOWN Cambridge				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 1003 Washington St.							
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Cornish				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) IF (YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 200-10-6473				17. INFORMANT Thomas Fisher				ADDRESS Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 4151 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few hrs.																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 2/25/80											
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr.				ADDRESS Cambridge, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 3/1/80				23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dor. Md.											
24. FUNERAL DIRECTOR NAME St. Clair Funerls				ADDRESS Cambridge, Md.				25a. DATE REC'D. BY REGISTRAR FEB 27 1980				25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>											

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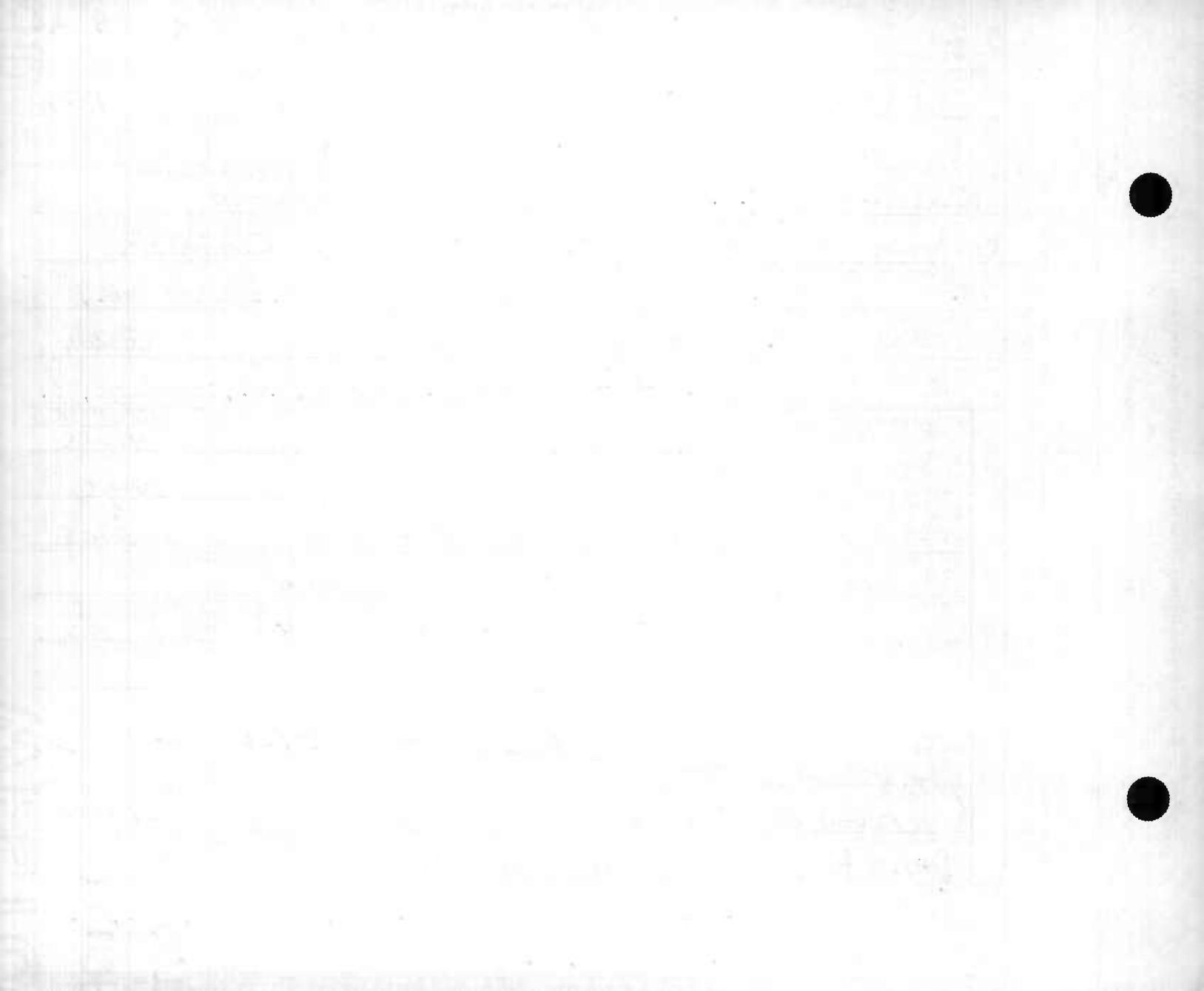
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 0 0 4 4 9 4			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				20. DATE OF DEATH			
EDNA FLUCK				2/26/80			
3 SEX Female				2b. HOUR 1:50 AM			
4 RACE Cauc.				5. DATE OF BIRTH 01-27-08			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dorchester				6. AGE (IN YEARS LAST BIRTHDAY) 71			
7b. CITIZEN OF WHAT COUNTRY? U.S.				8. IF UNDER 1 YEAR MONTHS DAYS			
10 CITY OR TOWN OF DEATH Cambridge Md.				9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Genl. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Beautician			
12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.				13b. COUNTY Dor.			
13c. CITY OR TOWN Cambridge				14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME James F. McCarter				15. MOTHER'S MAIDEN NAME Sarah Burton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 214-07-7018			
17 INFORMANT James F. McCarter, M.D., Cambridge, Md.				ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPSIS</u> 1889 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PERITONITIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARCINOMA OF BLADDER</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS DAYS WEEKS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>MALNUTRITION OF CHRONIC DISEASE</u>							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA OF BLADDER</u>			
19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/5</u> 19 <u>80</u> , to <u>2/26</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>2/25</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE David B. Stoeckle MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22c. DATE SIGNED 2/26/80				22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOECKLE MD			
22e. ADDRESS 400 AURORA ST. CAMBRIDGE, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Feb. 28, 1980			
23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park				23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.			
24. FUNERAL DIRECTOR Thomas Funeral Home, Cambridge, Md.				25a. DATE REC'D. BY REGISTRAR FEB 29 1980			
25b. REGISTRAR'S SIGNATURE [Signature]							

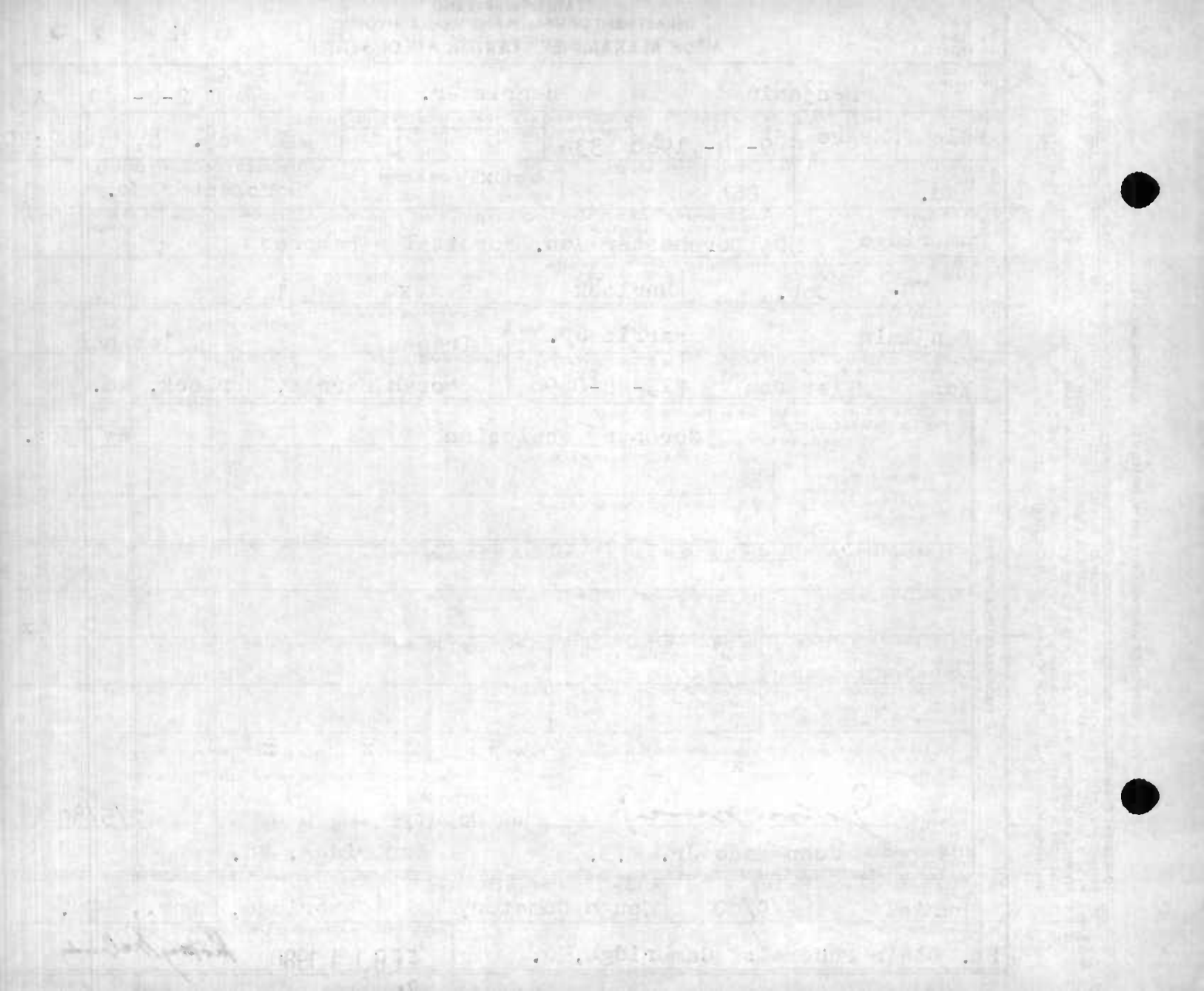


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 04495	
1. DECEASED NAME (TYPE OR PRINT) Benjamin Harris Jr.										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 2-4-80 YEAR 80 2b. HOUR AM	
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH 9-4-1946 DAY 33 YEAR YRS.		6. AGE (IN YEARS LAST BIRTHDAY) 33	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0	7c. DATE PRONOUNCED DEAD Feb. 4, 1980		2d. HOUR 2:20 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co. MD.				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA Dorchester Gen. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD 1			
14. FATHER'S NAME FIRST Benjamin MIDDLE Harris Sr. LAST Irene					15. MOTHER'S MAIDEN NAME FIRST Irene MIDDLE Fletcher LAST Fletcher						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. 213-44-0498		17. INFORMANT ADDRESS Deborah Harris, Hurlock, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John Mace Jr.</i>				TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER				DATE SIGNED 2/5/80			
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.				ADDRESS Cambridge, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/9/80		23c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		23d. LOCATION CITY OR TOWN Cambridge, Dor., Md. COUNTY Dor. STATE Md.			
24. FUNERAL DIRECTOR NAME St. Clair Funerals ADDRESS Cambridge, Md.						25a. DATE REC'D. BY REGISTRAR FEB 14 1980		25b. REGISTRAR'S SIGNATURE <i>Robert McBrady</i>			

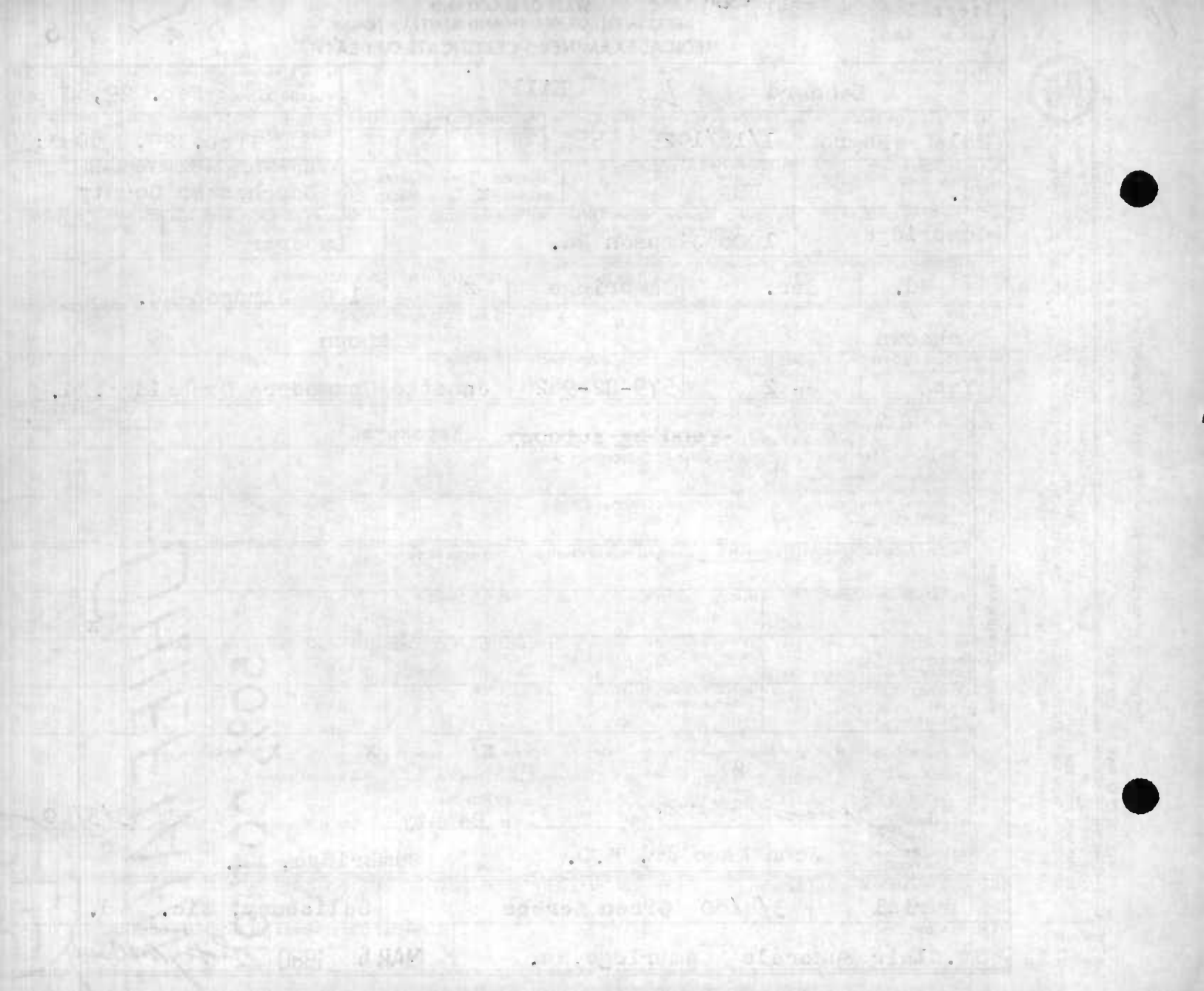


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

1- STATE FOR REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.																																																											
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH										MONTH DAY YEAR										7b. HOUR																																																	
Leonard										L. Hill										Feb. 29, 80										PM																																																											
3 SEX										4 RACE										5. DATE OF BIRTH										6. AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.										7c. DATE PRONOUNCED DEAD										MONTH DAY YEAR										7d. HOUR									
Male										Negro										1/18/1925										55																														Feb. 29, 80										PM																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										NEVER MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH										MD																																							
Md.										USA										WIDOWED										DIVORCED										Dorchester County																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
Cambridge										1008 Jimpson Rd.										Laborer																																																																					
13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																																	
Md.										Dor.										Cambridge										YES										1008 Jimpson Rd.																																																	
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																																															
Unknown										Unknown																																																																															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																																											
Yes										WW 2										579-22-9828										Janette Commodore Cambridge, Md.																																																											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																																					
9010										IMMEDIATE CAUSE (a) - Pending-autopsy Exposure																																																																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										DUE TO, OR AS A CONSEQUENCE OF																																																																															
										(b)																																																																															
										DUE TO, OR AS A CONSEQUENCE OF																																																																															
										(c)																																																																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																																																																									
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?																																																																					
																				YES										NO																																																											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																																																					
										HOUR A.M. MONTH DAY YEAR																																																																															
21d. INJURY OCCURRED WHILE AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION																																																																					
																				CITY OR TOWN										COUNTY										STATE																																																	
22a. I certify that I took charge of the remains described above, held on										Autopsy										Inspection										Inquiry										and in my opinion																																																	
death resulted from:										Natural causes										Accident										Suicide										Homicide										Undetermined manner																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED																																																																					
John Mace Jr.										M.D. Deputy										MEDICAL EXAMINER										3/3/80																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																																															
John Mace Jr. M.D.										Cambridge, Md.																																																																															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION																																																											
Burial										3/4/80										Green Acres										Salisbury, Wic. Md.																																																											
24. FUNERAL DIRECTOR										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																																																																					
NAME										ADDRESS																																																																															
St. Clair Funerals										Cambridge, Md.										MAR 6 1980										Ritzy McCready																																																											



BP

DHMA - 16 25M
(VR A 15 (4) 9/74)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 4 4 9 7

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Boy Hooper			2a. DATE OF DEATH MONTH DAY YEAR Feb. 25, 1980			2b. HOUR 6:43 A M			
3. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR Feb. 25 1980		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 0 0 31		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN 0 31	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 505 Elm St Cambridge		12b. KIND OF BUSINESS OR INDUSTRY 21613	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md		13b. COUNTY Dorchester		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Keith Ira Camper		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Velma Romona Hooper							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 7708 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min.	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25</u> , 19 <u>80</u> , to <u>Feb. 25</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Depue H. Duffey MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 3/3/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Depue H. Duffey, M.D.			22e. ADDRESS Byrn Street, Cambridge, Maryland						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Dorchester General Hosp.			ADDRESS Cambridge, Md.		25a. DATE RECD. BY REGISTRAR MAR 7 1980		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

TO : DIRECTOR, FBI (100-441100)
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]

[Illegible handwritten text]

[Illegible handwritten text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 16b g540 2/28/80 gj

FOR
1- STATE
REGISTRAR

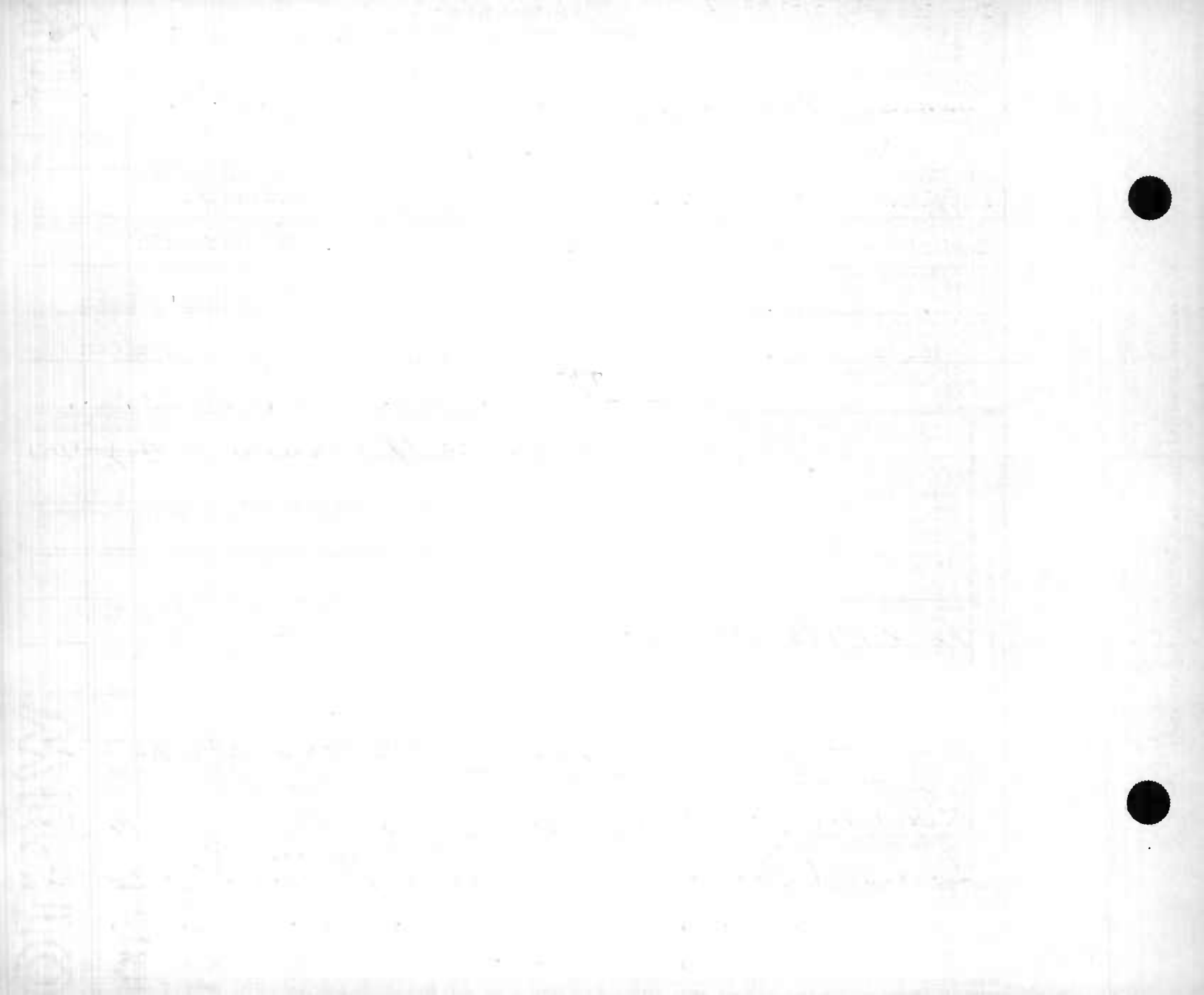
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 4 4 9 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Philip M. Johnson			2a. DATE OF DEATH MONTH DAY YEAR Feb. 12, 1980			2b. HOUR 04:55 P.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 71		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Genl. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Auto Mechanic		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 408 Leonard's Lane	
14. FATHER'S NAME FIRST MIDDLE LAST Herman S. Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nannie Spedden					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1534 214-07-7534		17. INFORMANT ADDRESS Mrs. Ruth S. Johnson, Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of cecum</u> 1534 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION Nov 1978			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED above			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 1978</u> to <u>Feb 12 1980</u> , that (I) (we) lost saw the deceased alive on <u>Feb 12 1980</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Lewis M. Burdette MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12 Feb 80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis M. Burdette						22e. ADDRESS 4 Aurora St Cambridge Md 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 15, 1980		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dor., Md.		
24. FUNERAL DIRECTOR Thomas Funeral Home, Cambridge, Md.						25a. DATE REC'D. BY REGISTRAR FEB 19 1980		25b. REGISTRAR'S SIGNATURE Hickory McCreedy	

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

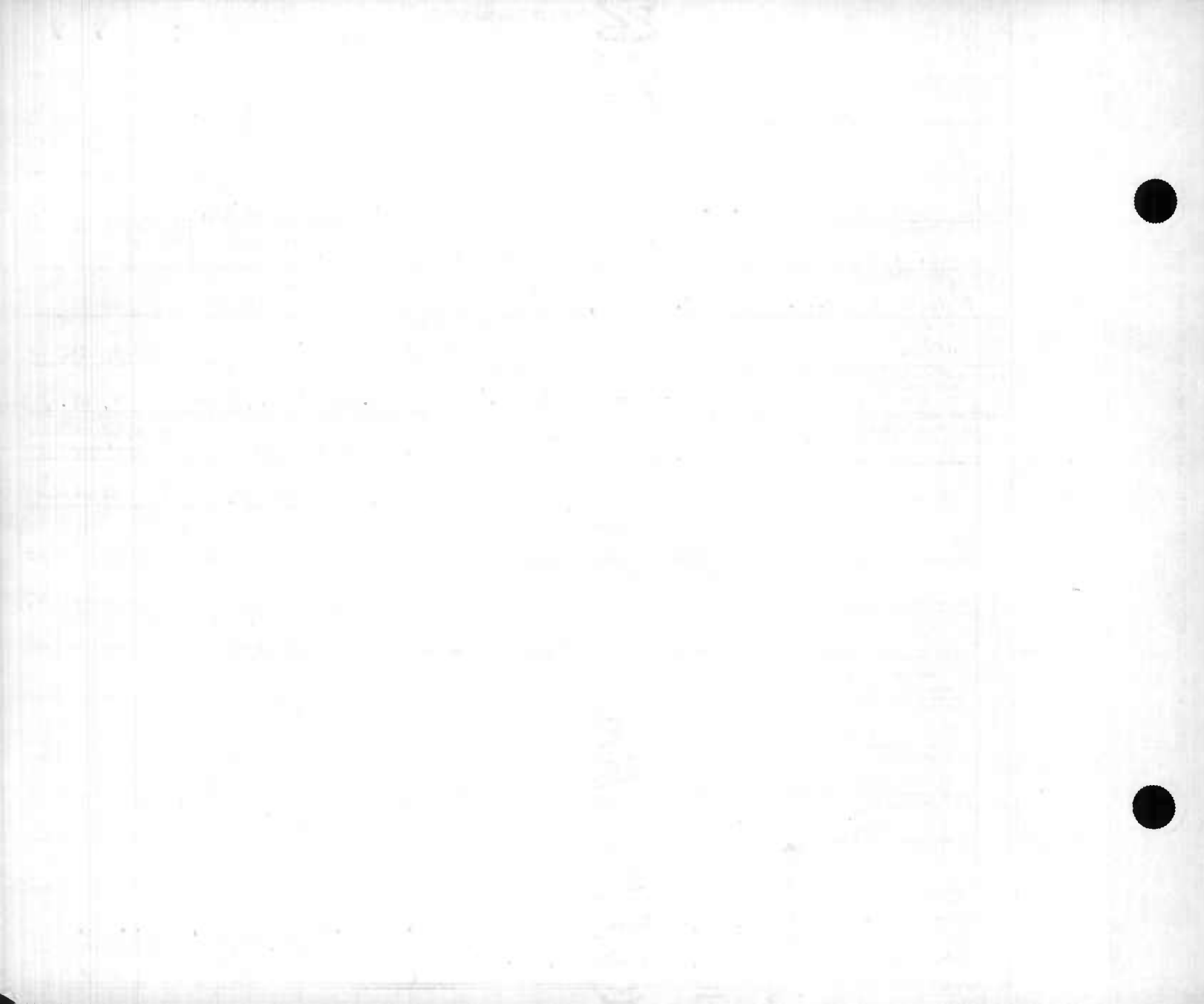
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	0	4	4	9	9
FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eva Keene										2a. DATE OF DEATH MONTH DAY YEAR 02-25-80				2b. HOUR M		
3 SEX Female			4 RACE Cau			5 DATE OF BIRTH MONTH DAY YEAR 03-24-00			6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dorchester			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.							
10 CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Dor.			13c. CITY OR TOWN C. Creek, RD			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rural				
14 FATHER'S NAME FIRST MIDDLE LAST John Wroten					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angie Rippons											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 220-07-0540			17 INFORMANT ADDRESS Mrs. Howard M. Sherman, Cambridge, Md.										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cholelithiasis & Refs to Kungs (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Casper					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 27, 1980			23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park			23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.							
24 FUNERAL DIRECTOR Thomas Funeral Home, Cambridge, Md.					25a. DATE REC'D. BY REGISTRAR FEB 29 1980			25b. REGISTRAR'S SIGNATURE [Signature]								

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 4 5 0 0
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M			
Mary			Andrews	Lou		February 21 1980						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female		Caucasian		May 28, 1881			98 YRS.		IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
MD		USA					Dorchester Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Hurlock			310 N. Main Street									
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
MD			Dorchester			Hurlock				310 N. Main Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
James			M.	Andrews		Sallie				Noble		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT						
No			045-05-1561			-A Rebecca Lord, 710 Smith St., Salisbury MD 21801						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 431- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Senility</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No.	City or Town	County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>December 25, 1985</u> , to <u>February 21, 1986</u> , that (I) (we) last saw the deceased alive on <u>February 21, 1986</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Charles F. Barroso MD</u>						DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>2-21-86</u>
22d. PHYSICIAN'S NAME (Type) <u>CHARLES F. BARROSO MD</u>						22e. ADDRESS <u>Hurlock Md. 21643</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			2-23-80		Unity Washington Cem.			Hurlock, Dorchester, MD				
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Zeller Funeral Home, East New Market MD									DATE <u>MAR 3 1986</u>		<u>Tracy K. [Signature]</u>	

STATE OF NEW YORK

IN SENATE,
January 10, 1907.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 15, 1906.

ALBANY:
J. B. LIPPINCOTT & COMPANY, PRINTERS,
1907.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 4 5 0 1

1 - FOR
STATE
REGISTRAR

REG. NO.

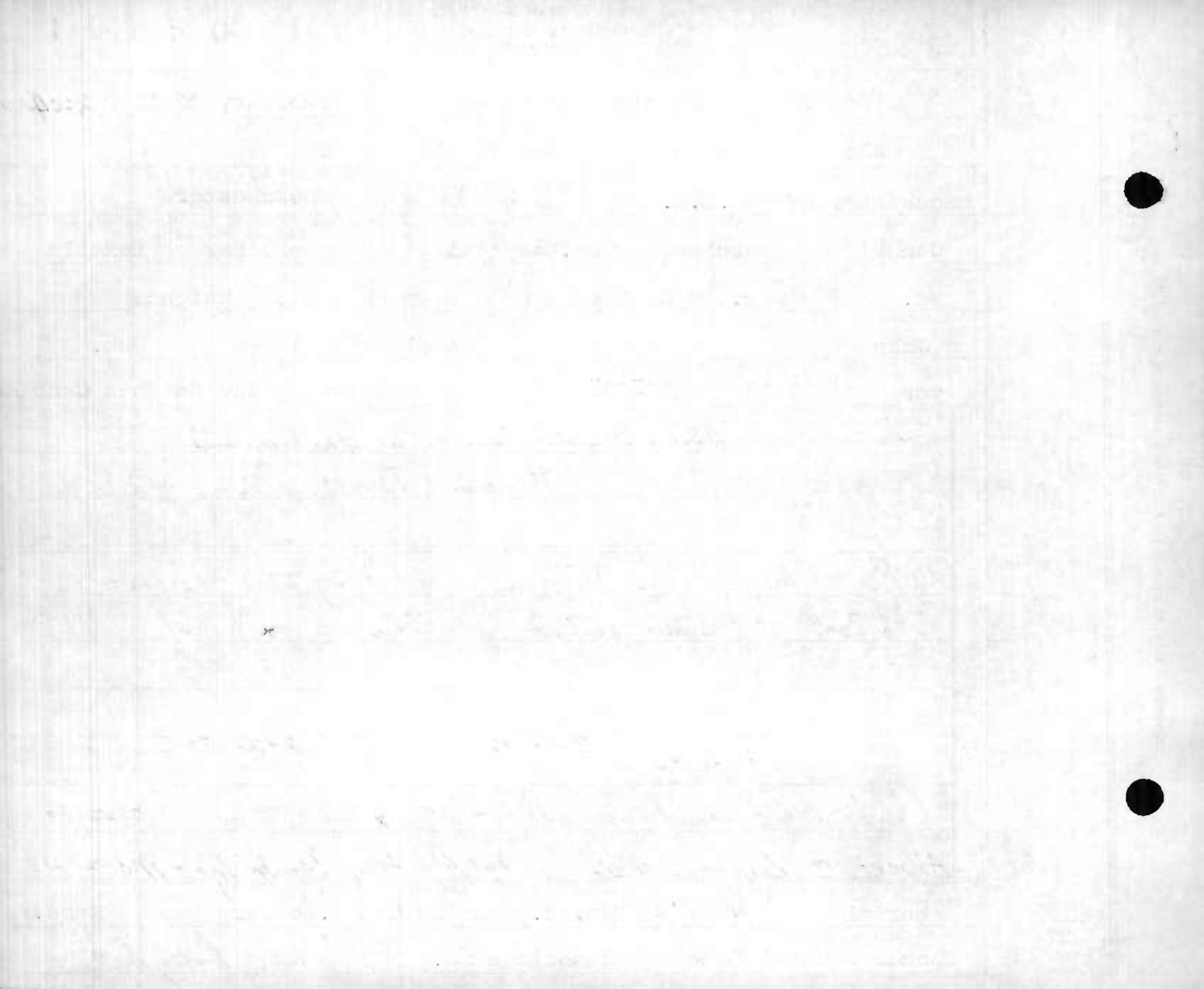
1 DECEASED NAME (TYPE OR PRINT) Edward Francis McDuffey			2a DATE OF DEATH MONTH DAY YEAR February 22 1980		2b HOUR 2:04am
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Feb 18 1894	6 AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS 86		IF UNDER 1 YEAR IF UNDER 1 HRS HOURS MIN
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Manchester NH	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD		
10 CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Gen. Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor	12b KIND OF BUSINESS OR INDUSTRY textile	
13a STATE Md.			13b COUNTY Dor.	13c CITY OR TOWN Cambridge	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST John McDuffey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mabel Unk.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1910		17 INFORMANT ADDRESS Mary Mathews 9 Bay Heights Camb Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE 4292 ASED with Congestive Failure and Terminal Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD - Chronic Brain Syndrome - Acid Peptic Disease					
19a DATE OF OPERATION 1-18-80 1-21-80		19b CONDITION FOR WHICH OPERATION WAS PERFORMED Chronic Bronchopneumonia Acid Peptic Disease		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 3-26-76 19____, to 2-22-80 19____, that (I) (we) lost saw the deceased alive on 2-21-80 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Albert P. Bunker - M.D.		DEGREE M.D.		22c. DATE SIGNED 2/22/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert P. Bunker - M.D.		22e. ADDRESS 200 Md Ave, Cambridge - Md. 21613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 2/26/80	23c. NAME OF CEMETERY OR CREMATORY Mt. St. Benedict Cem		23d. LOCATION CITY OR TOWN COUNTY STATE W. Roxbury Mass.	
24. FUNERAL DIRECTOR NAME Thomas Funeral Home		ADDRESS Cambridge Md.		25a. DATE REC'D. BY REGISTRAR FEB 25 1980	25b. REGISTRAR'S SIGNATURE Robert McBratney

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR	
Latayna Mae		Miller						2-6-		19		80				A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Female	Negro	1 - 12-1980		25		25				Feb. 6,		19		80		4AM M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Md.		USA		Dorchester County MD													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)															
Cambridge		D.O.A. Dorchester Gen. Hosp. None															
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)																	
None																	
12b. KIND OF BUSINESS OR INDUSTRY																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		524 Cedar St.									
14. FATHER'S NAME									15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST									FIRST MIDDLE LAST								
Larry Miller									Emojean Blake								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)									16b. SOCIAL SECURITY NO.								
No																	
17. INFORMANT									ADDRESS								
Emojean Blake									524 Cedar St. Cambridge, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) S.I.D. Syndrome																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED					
John Mace Jr.						Deputy						2-13-80					
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS											
John Mace Jr. M.D.						Cambridge, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
Burial						2-8-1980						Cross Roads Cemetery, Mr. Vianna, Dor, Md.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
Lewis H. Boardley						FEB 20 1980						Rufus McCreedy					

RECEIVED BY THE
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

THROUGH: [illegible]

BY: [illegible]

FOR: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8004503		
1. FOR STATE REGISTRAR					REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HEURICHA S. PURNELL					2a. DATE OF DEATH MONTH DAY YEAR 2 6 80			2b. HOUR 10³⁴ PM				
3. SEX FEMALE		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 3 22 76		6. AGE (IN YEARS LAST BIRTHDAY) 43 YRS.		7. UNDER 1 YEAR MONTHS DAYS 0 0		7. UNDER 24 HRS HOURS MIN. 0 0		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER CO. MD.						
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.					13b. COUNTY WICOMICO		13c. CITY OR TOWN SALISBURY		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS HIGH ST.	
14. FATHER'S NAME FIRST MIDDLE LAST CLAYTON PURNELL					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAY M. MCCOULLOUGH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 219-36-5267		17. INFORMANT ADDRESS JOHN B. PARSONS HOME SALISBURY, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA 436- DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Spastic Brain Syndrom												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE E. Tanman					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 2-7-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman					22e. ADDRESS 17 Franklin St. Cambridge, Md 21613							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 2/7/80		23c. NAME OF CEMETERY OR CREMATORY BELMARVA CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE LEWIS, DEL.				
24. FUNERAL DIRECTOR NAME ADDRESS LEVIN R. WILSON SALISBURY, MD.					25a. DATE REC'D. BY REGISTRAR FEB 11 1980			25b. REGISTRAR'S SIGNATURE Robert McCready				

BP _____

IN THE COURT OF THE

CLERK OF THE DISTRICT COURT

OF THE DISTRICT OF COLUMBIA

IN RE: THE ESTATE OF

JOHN A. ROBERTSON, DECEASED

FILE NO. 100-100000

DATE OF DEATH: 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 0 4 5 0 4
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADA GRACE ROSE			2a. DATE OF DEATH MONTH DAY YEAR 2-9-80			2b. HOUR 5:55 PM	
3 SEX F	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 6-23-96	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7. IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH DOR				
10 CITY OR TOWN OF DEATH Cambridge Md	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Eastern Shore Hosp. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.		13b. COUNTY DOR	13c. CITY OR TOWN VIENNA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Church St.		
14 FATHER'S NAME FIRST MIDDLE LAST THOMAS B SACKETT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTELL MOWBRAY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-14-0501		17. INFORMANT ADDRESS Anna Brewer Dnto			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 486- DUE TO, OR AS A CONSEQUENCE OF: (b) Pneumonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): Mental illness							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ± 3-4 wks.
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-8, 1980, to 2-9, 1980, that (I) (we) lost saw the deceased alive on 2-9-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Nestor J. Galarza MD		DEGREE		22c. DATE SIGNED 2-9-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nestor J. Galarza		22e. ADDRESS Eastern Shore Hospital Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-13-80		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Vienna Dorch. MD	
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, East New Market				25a. DATE REC'D. BY REGISTRAR FEB 19 1980		25b. REGISTRAR'S SIGNATURE Hickey McBrady	

BP



THE UNIVERSITY OF CHICAGO
DEPARTMENT OF CHEMISTRY
CHICAGO, ILLINOIS 60637

POST OFFICE BOX 5066 CHICAGO, ILL. 60680

1. NAME _____

2. ADDRESS _____

3. CITY _____

4. STATE _____

5. ZIP _____

6. PHONE _____

7. TELETYPE _____

8. TELEFAX _____

9. EMAIL _____

10. DATE _____

11. REMARKS

12. REMARKS

13. REMARKS

14. REMARKS

15. REMARKS

16. REMARKS

17. REMARKS

18. REMARKS

19. REMARKS

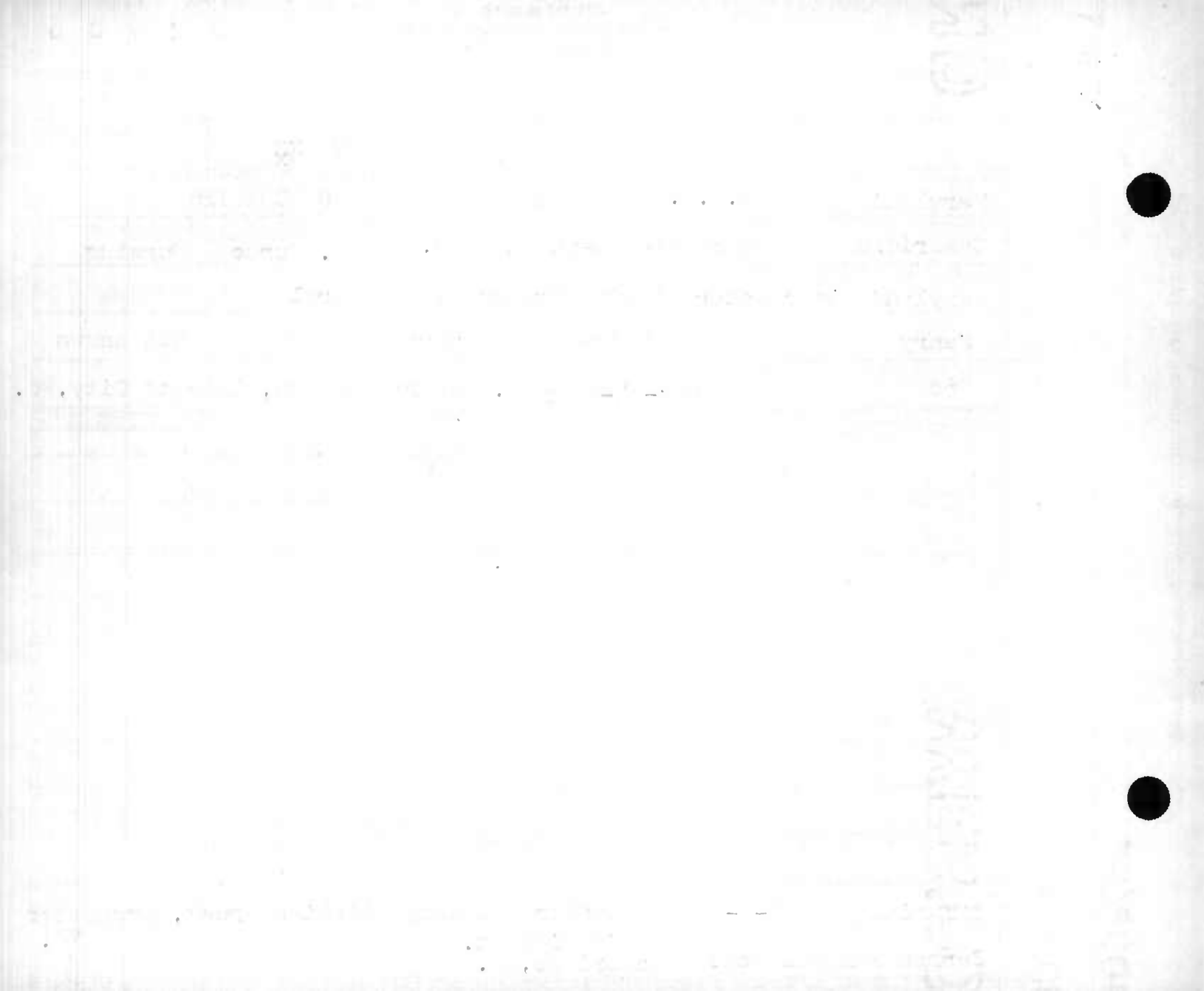
20. REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 0 0 4 5 0 5													
1. FOR STATE REGISTRAR				REG. NO.																			
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Clara E. Spedden										2		6		80				6:30 P.M.					
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR				8. IF UNDER 24 HRS.			
Female				Caucasian				11 29 82				87				MONTHS				DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				U.S.A.								DORCHESTER											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Cambridge				Dorchester General Hosp.				Prac. Nurse				Nursing											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. STATE				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Maryland				Dorchester				Fishing Creek				NO				Rural							
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME																			
Henry				Phillips				Nora				Not known											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
NO				212-12-3795				Mr. Robert Spedden				Ellicott City, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
IMMEDIATE CAUSE (a) _____										_____													
5990 DUE TO, OR AS A CONSEQUENCE OF _____										_____													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										_____													
DUE TO, OR AS A CONSEQUENCE OF _____										_____													
DUE TO, OR AS A CONSEQUENCE OF _____										_____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										_____													
Organic Brain Syndrome										_____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
								YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
				HOUR A.M. MONTH DAY YEAR																			
				P.M. 19																			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION															
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK								STREET				CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED											
E. Tanman				M.D.								2-6-80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS																			
E. Tanman				17 Franklin St. Cambridge, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				2-9-80				Hosier Cemetery				Fishing Creek, Dorchester											
24. FUNERAL DIRECTOR				308 High St. Cambridge, Md.				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Curran Funeral Home								FEB 11 1980				M. J. Kelly											



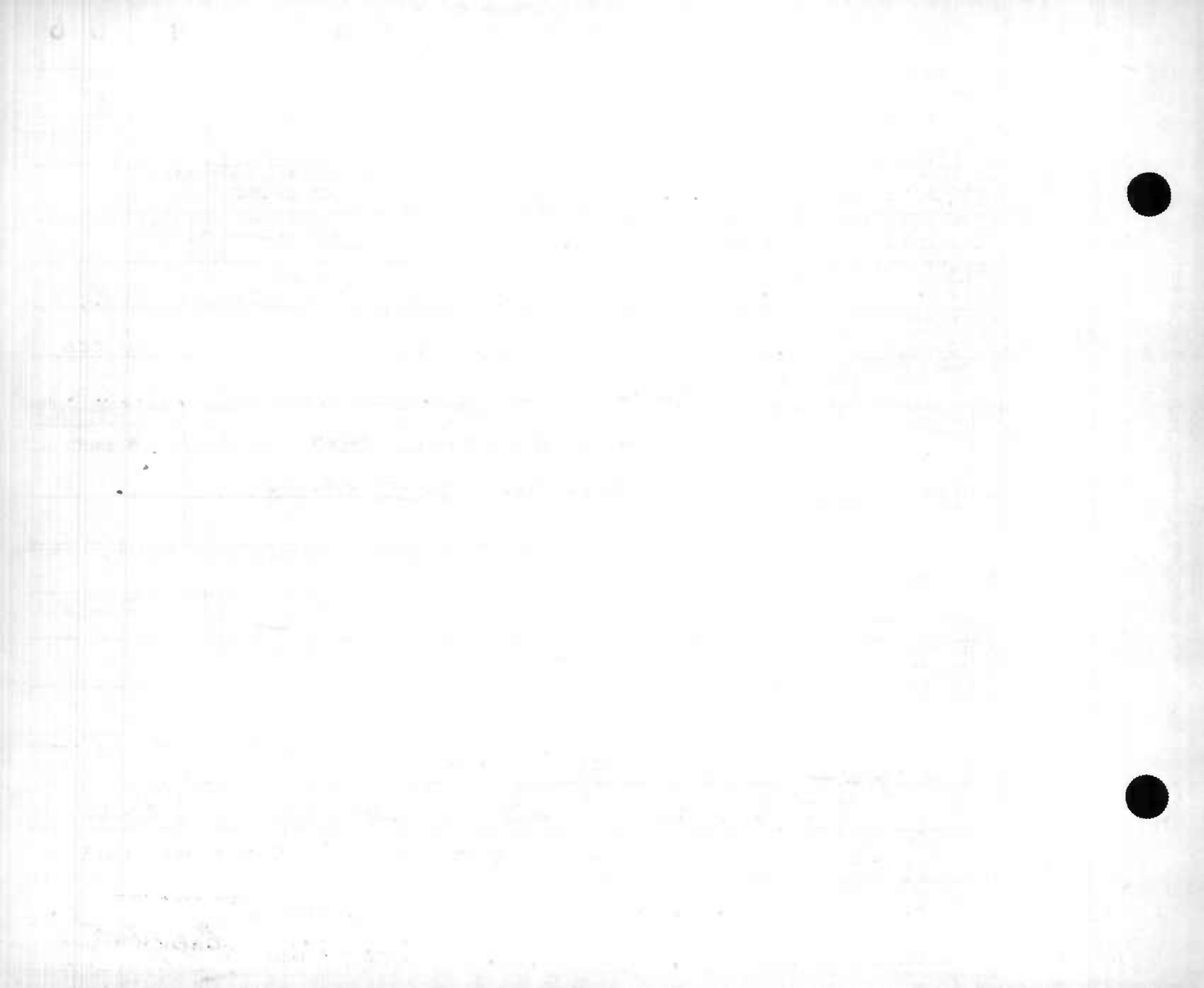
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8004506													
1. FOR STATE REGISTRAR										REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST			2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
John			G		Steele					2		9		80		3:40		P M					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. UNDER 1 YEAR			8. UNDER 24 HRS								
Male			Caucasian			6 30 83			96 YRS.			MONTHS			DAYS			HOURS			MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH														
Ayr, Scotland			U.S.						Dorchester														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Cambridge			Dorchester Genl. Hospital			Engraver																	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
										Md.		Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		311 Glenburn Ave.,					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																		
FIRST MIDDLE LAST					FIRST MIDDLE LAST																		
John C. Steele					Christene Geddes																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS													
NO					097-01-1509					Austin N. Steele, Cambridge, Md., R.D. 3													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I DEATH WAS CAUSED BY:																							
IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST										anxiety													
4292 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										CONGESTIVE HEART FAILURE													
DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																							
SENILE DEMENTIA																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
-								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
				HOUR A.M. MONTH DAY YEAR																			
				P.M. 19																			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION															
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								CITY OR TOWN				COUNTY STATE											
22a. I certify that (1) (this hospital) attended the deceased from 2/8 19 80, to 2/9 19 80, that (1) I saw the deceased alive on 2/9 19 80, and that in my (own) opinion death occurred on the date and hour and from the causes stated above, (2) I (did not) view the body after death.																							
22b. SIGNATURE								DEGREE				22c. DATE SIGNED											
XZ Fierzy								MD				2/9/80											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS															
HUBERT L. FIERZY MD								6 AURORA ST. CAMB MD 21613															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION											
Burial				Feb. 12, 1980				Hillside Cemetery, Roslyn,				CITY OR TOWN COUNTY STATE											
												Pa.											
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
NAME Thomas Funeral Home, Cambridge, Md.								ADDRESS				FEB 13 1980											
												Ruthy McCreedy											

BP



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BP

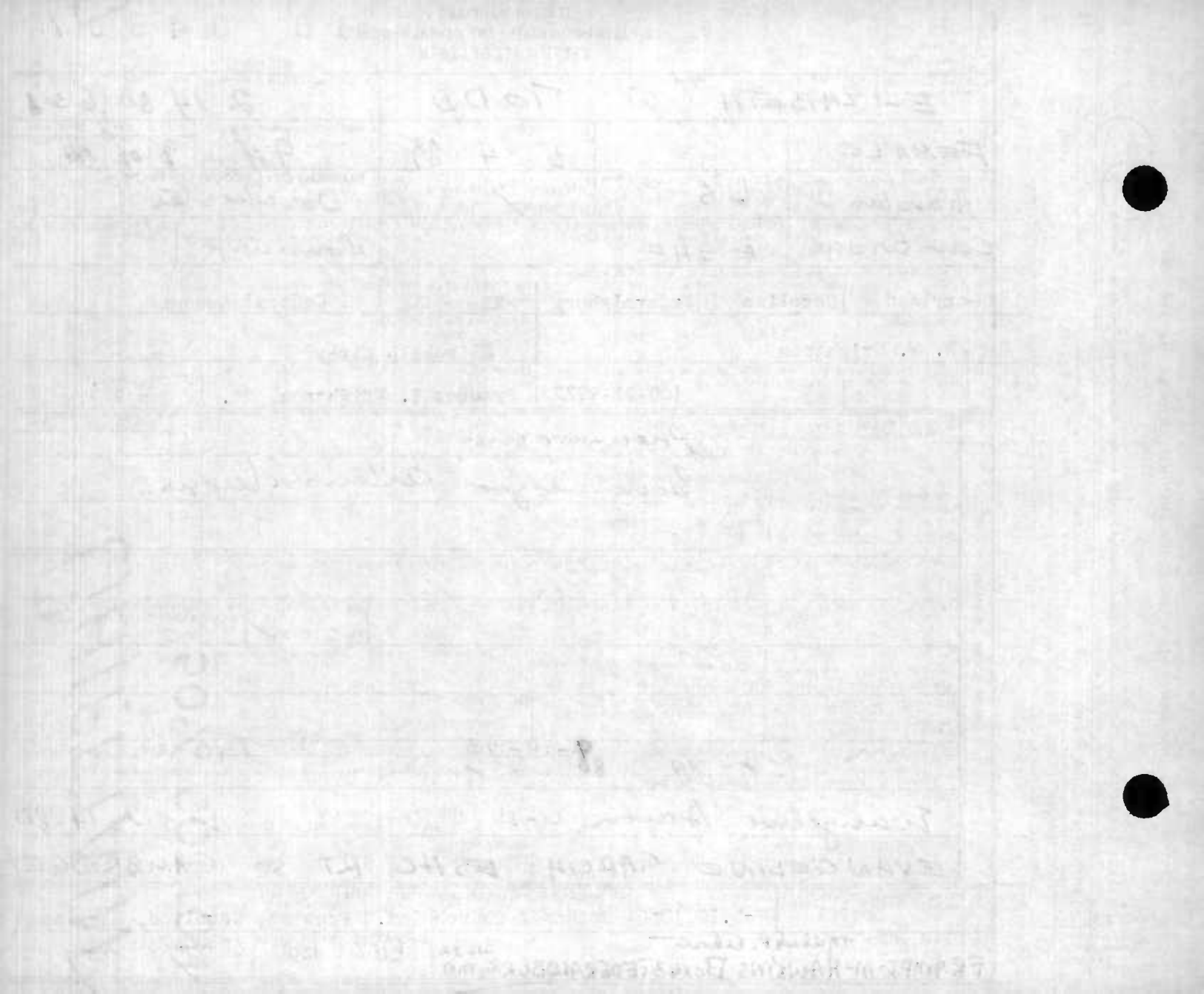
DHMH - 16 50M 7/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH W TOLD			2a. DATE OF DEATH MONTH 2 DAY 14 YEAR 80			2b. HOUR 6:30 AM			
3. SEX FEMALE		4. RACE		5. DATE OF BIRTH MONTH 3 DAY 4 YEAR 89		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) E.S.H.C.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland				13b. COUNTY Caroline		13c. CITY OR TOWN Federalsburg			
14. FATHER'S NAME FIRST W. W. MIDDLE Wrightson LAST				15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE Kirby LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 100-01-9922		17. INFORMANT ADDRESS Preston, Md. Frances T. Wrightson, Rt. 1, Box 279,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4409 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 9-10-73 , 19 80 , to 2-14-80 , that (I) (we) last saw the deceased alive on 2-14-80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Evangelina Garcia, M.D. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED 2-14-80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EVANGELINE GARCIA						22e. ADDRESS ESHC RT 50 CAMBRIDGE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 18, 1980		23c. NAME OF CEMETERY OR CREMATORY Bethesda Church Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Preston, Caroline, Maryland		
24. FUNERAL DIRECTOR NAME Michael P. Ekins ADDRESS 21632						25. DATE RECEIVED BY REGISTRAR FEB 20 1980		26. REGISTRAR'S SIGNATURE [Signature]	
FRAMPTON-HAWKINS Box 43 FEDERALSBURG, MD									



CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Alice M. Trice			2a. DATE OF DEATH MONTH DAY YEAR 02-08-80			2b. HOUR 3:40 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 07-21-14		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) dietary aide	
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Eugene Cleveland Trice				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulu Bradley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-56-2099		17. INFORMANT ADDRESS Mrs. Gladys Woolford Item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral pulmonary edema 4291 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Dependent Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (c) Dependent Heart Disease							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cerebral Venous Thrombosis							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 02/13/80 to 2/8/80 , that (I) (we) last saw the deceased alive on 2/8/80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 2/9/1980		23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.	
24. FUNERAL DIRECTOR NAME Thomas Funeral Home				ADDRESS Cambridge Md.		25a. DATE RECEIVED BY REGISTRAR FEB 13 1980	
25b. REGISTERED SIGNATURE [Signature]							

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BP

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100
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FOR
1- STATE
REGISTRAR

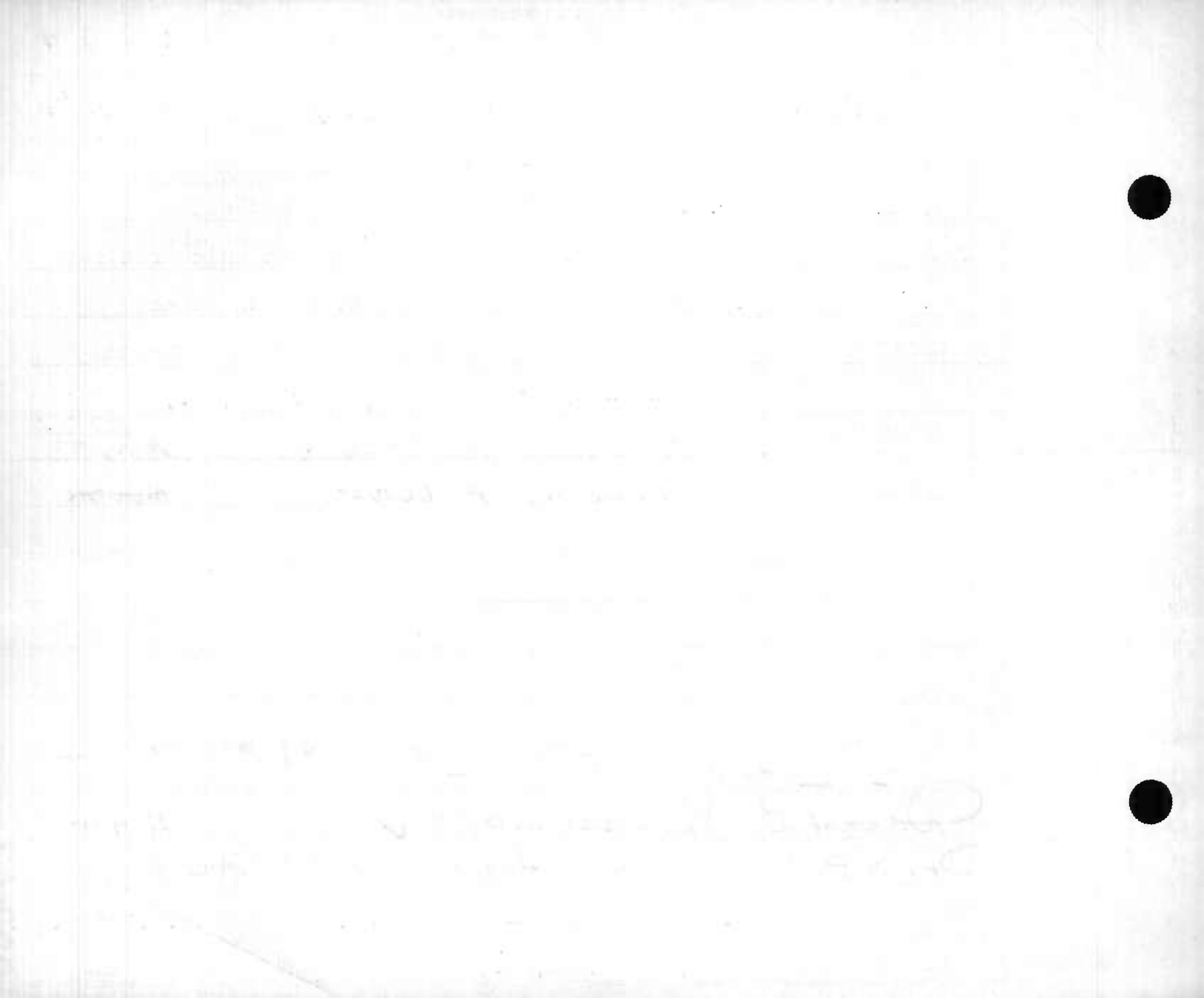
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 0 4 5 0 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert G. Ward			2a. DATE OF DEATH MONTH DAY YEAR 2-19-80			2b. HOUR 11:30 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 20, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7b. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester Genl. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) auto mechanic			12b. KIND OF BUSINESS OR INDUSTRY retired		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1710 Race street		
14. FATHER'S NAME FIRST MIDDLE LAST William Ward				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Mae Courtney							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 220-12-1626		17. INFORMANT ADDRESS Wilsie Ward, Cambridge, Md.,						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CARCINOMA LUNG</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES MONTHS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/14</u> 19 <u>80</u> , to <u>2/19</u> 19 <u>80</u> , that (I) last saw the deceased alive on <u>2/19</u> 19 <u>80</u> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (If you (did) not view the body after death.											
22b. SIGNATURE David B. Stoeckle MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/19/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOECKLE						22e. ADDRESS 400 AURORA ST. CAMB. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 22, 1980		23c. NAME OF CEMETERY OR CREMATORY Seward-Spedden Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge Dor. Md.			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.,						25a. DATE REC'D. BY REGISTRAR FEB 25 1980		25b. REGISTRAR'S SIGNATURE Lester McCreedy			

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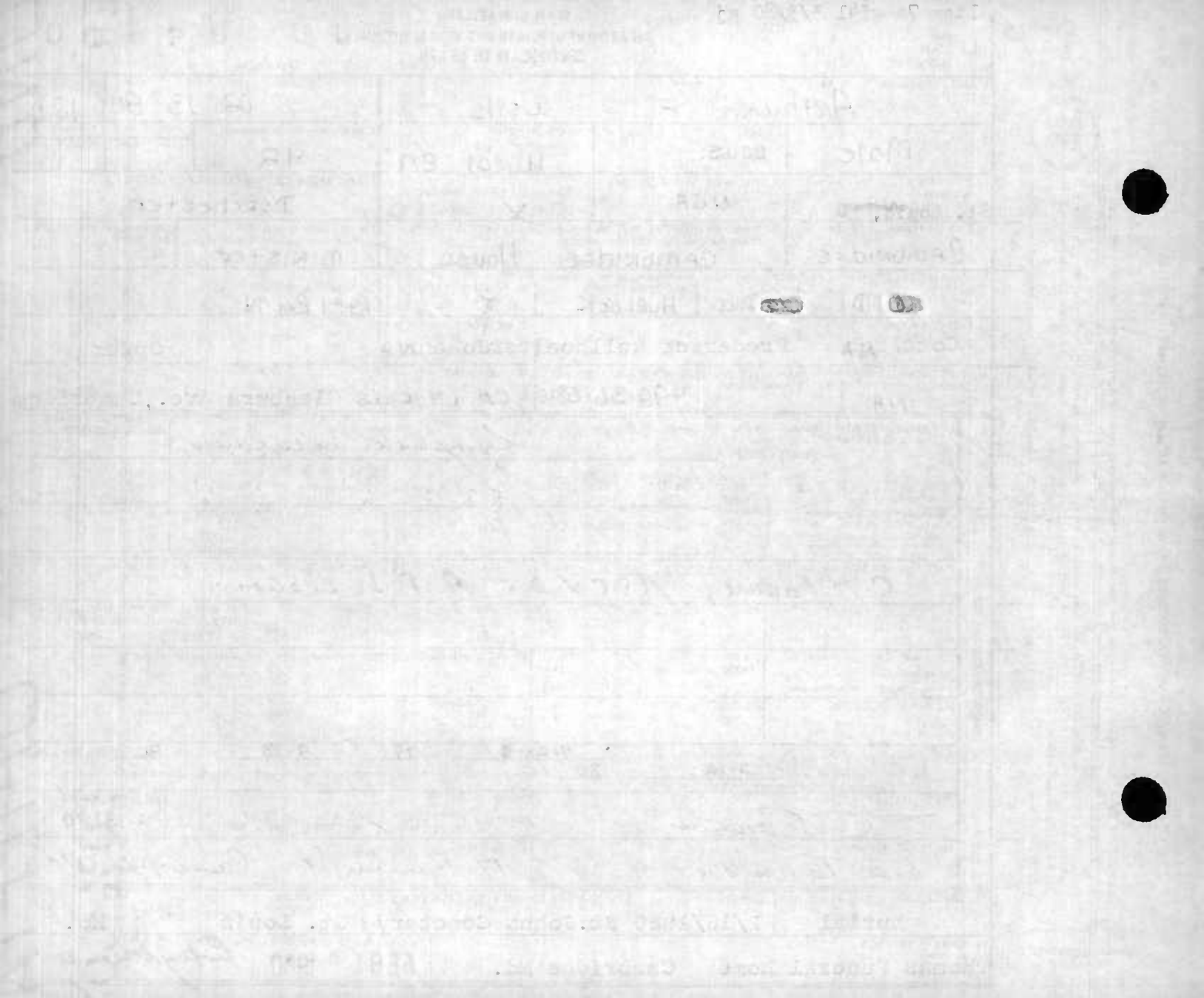
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO.										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur F Wells					2a. DATE OF DEATH MONTH DAY YEAR 02 13 80					2b. HOUR 12 ³⁰ PM
3. SEX Male		4. RACE caus.		5. DATE OF BIRTH MONTH DAY YEAR 11 01 87		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) St. Louis, MO		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) minister		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD					13b. COUNTY Dorc.		13c. CITY OR TOWN Hurlock		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Gottlieb Frederick					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna A. Opfer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NA		16b. SOCIAL SECURITY NO. 492-36-5815		17. INFORMANT ADDRESS CH Records Glenburn Ave., Cambridge						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CH Failure, ASCVD & A. Fibrillation</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>7-28-80</u> 19 <u>79</u> to <u>2-13</u> 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>E. Tanman</u>					DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2-13-80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman					22e. ADDRESS 17 Franklin St. Cambridge, Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 2/16/1980		23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE St. Louis Mo.				
24. FUNERAL DIRECTOR NAME Thomas Funeral Home					ADDRESS Cambridge Md.		25a. DATE REC'D. BY REGISTRAR FEB 19 1980		25b. REGISTRAR'S SIGNATURE <u>Henry McBrady</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 50M17/77
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

80 04511

CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	7b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2	3	80
James H. Wilson						12 45 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
m	Negro	MONTH DAY YEAR		80 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dorchester MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Cambridge Md.		Water man			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md.		Queen Anne		Grasonville		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
HARRY		LIZZA		No -		218-01-8190	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____		19. DATE OF OPERATION		20a. AUTOPSY?	
Freeman		Cardio-Pulmonary Arrest		4-27-80		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. LOCATION		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (TYPE OR PRINT)	
17		E. Tanman		2-3-80		E. Tanman	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
		2/9/80		Reberson Cem.		Grasonville	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
L. P. DeWitt		FEB 6 1980		History, K. DeWitt			

MEDICAL CERTIFICATION

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Gangrene of R foot, Organic Brain syndrome

20a. AUTOPSY? YES ☐ NO ☐ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION

24. FUNERAL DIRECTOR 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25c. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For deaths occurring in the hospital, the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	0	0	4	5	1	2
1. FOR STATE REGISTRAR										REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) Mildred E. Windsor <i>MILDRED E. WINDSOR</i>										2a DATE OF DEATH MONTH DAY YEAR 2 20 80				2b HOUR 10 A M		
3 SEX female		4 RACE cau.		5 DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1906			6 AGE (IN YEARS LAST BIRTHDAY) 73 yrs.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester					MD.				
10 CITY OR TOWN OF DEATH Cambridge		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) crab-picker			12b KIND OF BUSINESS OR INDUSTRY seafood					
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.		13b COUNTY Dorchester		13c CITY OR TOWN Wingate		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS rural 21675 (zip)								
14 FATHER'S NAME FIRST MIDDLE LAST Cleveland Tawes				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Taylor												
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b SOCIAL SECURITY NO 212-12-3286		17 INFORMANT ADDRESS Mr. W. Windsor, Wingate, Md. 21675										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Class IV C. i. F. 4140 DUE TO, OR AS A CONSEQUENCE OF (b) AS 40 Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) Brain yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Weeks						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22 I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b SIGNATURE <i>On the mill</i>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED						
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS												
23a BURIAL, CREMATION, REMOVAL (SPECIFY) burial				23b DATE Feb. 23, 1980		23c NAME OF CEMETERY OR CREMATORY Dorchester Mem. Pk.			23d LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dor., Md.							
24 FUNERAL DIRECTOR NAME Curran Funeral Home, 3085 High St.				25 DATE RECD. BY REGISTRAR FEB 25 1980				25b REGISTRAR'S SIGNATURE <i>Barbara McCurdy</i>								

